THE RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

Dear Provider:

The Rhode Island Medical Assistance Program (RIMAP) is continually reviewing ways to further improve our claims processing accuracy and consistency by employing the latest in proven computer technology.

In October, EDS will be implementing ClaimCheck®, an expert system that assists in evaluating the accuracy of submitted CPT® and HCPCS codes. By "thinking" the same way a physician-reviewer would, ClaimCheck uses a clinical knowledge base that results in a medically based recommendation. The outcome may be one of the following:

1) To accept the code(s) as submitted.
2) To consider changing the submitted code(s) to comply with generally accepted coding practices that are consistent with the American Medical Association's (AMA) CPT manual, the Centers for Medicare and Medicaid Services, (CMS), HCPCS Level II Codes manual, as well as the opinions of prominent physicians within the medical specialty.
3) To seek additional information from the physician's office because there is inconsistent information on the claim.
4) To deny the claim based on clinical review

ClaimCheck evaluates the coding accuracy of the procedure(s), not the medical necessity of the procedure(s). The types of services that will be evaluated by ClaimCheck are as follows:

- Policies based on the CPT manual
- Policies based on health care coding standards
- Bundling/Unbundling of procedures
- Global periods (pre and post surgery)
- Multiple procedures performed same day
- Appropriateness of assistants at surgery
- The proper use of modifiers

The procedural determination is gathered through resources such as the Center for Medicare & Medicaid Services, Federal Register, CPT, HCPC, American College of Surgeons, Code Auditing Advisory Committee and (but not ending) a board of Specialty Physicians across America. This type of editing has been in place in all Blue Cross Blue Shield commercial carriers as well as a multitude of others.

You will find attached documentation outlining the guidelines for claim check edits.

Thank you for your continued support and the quality care you provide to our members. If you have any questions or concerns please contact Provider Services at 1-800-964-6211 for instate toll calls and bordering communities and 401-784-8100 for long distance callers.

Sincerely,

EDS Provider Services

Claim Check Edit	Definition
Rebundling	Procedure unbundling occurs when two or more procedure codes are used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service performed by a provider.
Incidentals	Certain procedure codes are commonly performed in conjunction with other procedures as a component of the overall service provided. An *incidental* procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure
Does Not Require Assistant Surgeon	Designations were developed on a procedure-by-procedure basis using literature reviews, clinical expertise, and published guidelines by specialty organizations and not strictly aligned with any single source. Based on input from the Code Auditing Advisory Committee members, the Clinical Affairs Department and the American College of Surgeons have identified clinical guidelines for procedure codes billed with an Assistant Surgeon (AS).
Modifier 25	Modifier 25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.
Mutually Exclusive	Mutually Exclusive edits consist of combinations of procedures that differ in technique or approach but lead to the same outcome. In some instances, the combination of procedures may be anatomically impossible. Procedures that represent overlapping services or accomplish the same result are considered mutually exclusive. In addition, reporting an initial service and subsequent service is considered mutually exclusive.
Not indicated for Separate Reimbursement	A reimbursement edit is developed based on Healthcare reimbursement policies for which no clinical rationale exists.
Modifier 59	Submitting modifier –59 with a procedure indicates that a distinct procedural service was performed; separate from other services rendered on the same day by the same provider.
Cosmetic	A number of surgical procedures may be performed without a medically indicated purpose, and are considered cosmetic in nature. Usually, the procedure is requested by the patient to improve physical appearance. Most health insurers will not pay for cosmetic procedures or for cosmetic aspects of an otherwise medically indicated procedure.